Joint Committee on Boards, Commissions and Consumer Protection

# BACKGROUND PAPER FOR HEARING JANUARY 5, 2005

# OSTEOPATHIC MEDICAL BOARD

## BACKGROUND, IDENTIFIED ISSUES, AND QUESTIONS

## BRIEF OVERVIEW OF THE OSTEOPATHIC MEDICAL PROFESSION AND THE OSTEOPATHIC MEDICAL BOARD

The Osteopathic Medical Board (Board) has jurisdiction over Doctors of Osteopathy (D.O.s). D.O.s are fully licensed physicians. They differ from Medical Doctors (M.D.s) primarily in that their training and education have an additional focus on the interdependence of the body's various systems, including its musculoskeletal system (the human body's muscles, bones and joints).

The Board is a consumer protection board within the Department of Consumer Affairs (DCA).[1] It has the responsibility and sole authority to issue licenses to physicians and surgeons who hold a D.O. license to practice osteopathic medicine in California. The Board is responsible for ensuring enforcement of legal and professional standards to protect California consumers from incompetent, negligent or unprofessional D.O.s. The Board regulates D.O.s only. There are currently about 2700 D.O.s in California with licenses and another 1270 D.O.s who maintain licenses in California while residing in other states. There are approximately 760 D.O.s who maintain inactive licenses.

The Board was initially established as the Board of Osteopathic Examiners by initiative statute in 1922. That initiative established regulation by an entity separate from the Medical Board of California (MBC) because of a perception of discrimination against

[1] This description is taken, in large part, from the Board's Sunset Review Report. For more detailed information, refer to that' report's much more extensive discussion.

D.O.s by the predecessor to the MBC. At the time, there was a strain of mainstream medicine that viewed physicians trained in osteopathic medicine as lesser professionals. In 1919, they succeeded in halting the Board of Medical Examiners' longstanding practice of licensing osteopathic trained physicians. The 1922 initiative assured the continued existence of D.O.s as a licensed branch of the medical profession.

Subsequent initiative statutes have modified the initial law, and it is clear that the Legislature has considerable authority to amend the osteopathic law. Unlike the Chiropractic Act (which was also enacted by initiative but is not amendable), a 1962 initiative explicitly allows the legislature great leeway to amend the Osteopathic Act. In fact, the only restriction on the Legislature's power is that it may not fully repeal the Act unless the number of licensed D.O.s falls below 40. (Osteopathic Initiative Act, sec. 3600-3) Short of that, the Legislature may make any amendment to the act that it finds appropriate.

Prior to 2002, the Board was an independent, free-standing board. In 2002, pursuant to SB 26 (Figueroa), the Board was brought within the auspices of the state's other consumer-protecting boards and commissions – including the MBC -- in the Department of Consumer Affairs (DCA).

D.O.s are similar to M.D.s in that both are considered to be "complete physicians." Briefly, this means both D.O.s and M.D.s have unrestricted licenses to practice as physicians and surgeons in California. Both have taken the prescribed amount of premedical training, graduated from an undergraduate college (with a typical emphasis on science courses) and received four years of training in medical school. Physicians must also have received at least one additional year of postgraduate training (residency or rotating internship) in a hospital with an approved postgraduate training program.

A D.O. may refer to himself/herself as a doctor, but in doing so, must clearly state that he/she is a D.O. or osteopathic physician and surgeon. He or she may not state or imply that he or she is an M.D. while being licensed in California as a D.O.

To meet its responsibilities for regulation of the D.O. profession, the Board is authorized by law to:

1. Monitor licensees for continued competency by requiring approved continuing education.

2. Take appropriate disciplinary action whenever licensees fail to meet the standard of practice.

3. Determine that osteopathic medical schools and hospitals are in compliance with medical education curriculum and post-graduate training requirements.

4. Provide rehabilitation opportunities for licensees whose competency may be impaired due to abuse of alcohol or other drugs.

Additionally the Board is charged with enforcement of laws proscribing unlicensed osteopathic medical practice.

Under current law, the Board is comprised of seven members: five D.O.s and two public members, all of whom are appointed by the Governor. Members serve for terms of three years, and no member may serve more than three full consecutive terms, which does not include time a new member may spend filling an unexpired term of a previous member. Currently two D.O. members have terms expiring on June 1, 2005 and three are serving terms expiring June 1, 2006. The two public member positions expired on January 1, 2004. One of these positions is currently vacant. The other public member continues to serve under a one year grace period, which will expire on January 1, 2005. Thus, unless the Governor promptly makes appointments, as of January 1, 2005, the Board will officially have no public members at all.

| BOARD MEMBER NAME | APPOINTED BY | APPOINTED DATE | TERM EXPIRATION |
|---|---|---|---|
| K. Timothy Yu, Vice President | Governor | 05/01/02 | 01/01/04 |
| Michael J. Feinstein, Secty/Treasurer | Governor | 02/03/03 | 06/01/05 |
| Tracey L. Norton, Board Member | Governor | 11/06/03 | 06/01/06 |
| Jeffrey C. Young, Board Member | Governor | 10/23/03 | 06/01/05 |
| Jimmy Yue, Board Member | Governor | 10/29/03 | 06/01/06 |
| Vacant, Public Member | Governor | | |
| Vacant, Public Member | Governor | | |
| Vacant, Professional Member | Governor | | |

# SIGNIFICANT CHANGES SINCE LAST REVIEW

The most significant and consequential change since the last sunset review was to bring the Board within the ambit of the state's DCA. This has had both positive and negative implications for the Board, which will be discussed in more detail below.

Other changes include:

- In 1999, a clerical staff position was added. An office assistant was hired to perform the duties of receptionist/licensing clerk. The Office Technician now handles all license renewals and monitors continuing medical education compliance. The staff services analyst is currently handling the administrative assistant and enforcement tracking duties, in addition to business services duties, i.e., contract requests, personnel matters.

- In October 2001, the Board began utilizing the Consumer Affairs System (CAS) to maintain osteopathic physicians license data. In 2002, Board added the enforcement tracking and probation tracking programs of the CAS to our database.

- Since the last sunset report the Oral/Practical Licensing Examination has been eliminated (SB364 2003). Applicants must complete the first year of postgraduate training, as well as, successfully complete the National Board of Osteopathic Medical Examiners COMLEX Levels I through III examinations prior to submitting an application for licensure. Stringent safeguards are in place to evaluate all applicants' training and background.

- In 2003, a website was created to assist consumers, licensees and applicants for licensure.

- The license application process was streamlined by making the application forms available on the Board website. Like many other DCA boards, the Board utilizes the Department of Justice's Applicant LiveScan system for the electronic submission of applicant fingerprints and the subsequent automated background check and response. LiveScan technology replaces the process of recording an individual's fingerprint patterns manually through a rolling process using ink and a standard 8" x 8" fingerprint card, transforming fingerprints through an electronic process which enables the electronic transfer of the fingerprint image data, in combination with personal descriptor information, to central computers at the Department of Justice. This transfer of information takes place in a matter of seconds, instead of the days required to send hard copy fingerprint cards through the U.S. mail. Live Scan processing is only available to applicants residing in California. Out-of-state applicants must continue to use the hard copy fingerprint cards. The use of the Live Scan Process has cut the fingerprint process time in half.

# NEW ISSUES

## ISSUE #1: Should regulation of D.O.s be continued?

**Issue #1 question for the Board and DCA**: *Should the state continue to regulate Doctors of Osteopathy?*

**Background:** Unlike most boards within the DCA, the Osteopathic Medical Board (Board) was created by initiative, not by legislation. Consequently, the Legislature, itself, could not abolish the Board entirely (unless the number of licensed D.O.s in California falls below 40, in which case the Legislature is authorized by the initiative to formally dissolve the Board).

Nevertheless, the question the Committee asks of all other boards continues to be relevant – is there a continued need to regulate D.O.s?

Virtually all states license physicians. In addition, twenty states license D.O.s separately from M.D.s

Like other doctors, the public relies on D.O.s for a broad range of critical services regarding their health care which require a high degree of education, training, professional judgment, and complex technical skills. Incompetence and malfeasance by D.O.s carry the greatest potential for causing patient harm, and patients generally are not sufficiently knowledgeable or sophisticated to deal with problems they may face without the help of experts who staff boards like the current one.

While patients have recourse to private civil action for negligence or fraud, exercise of these rights can be prohibitively costly or time consuming. Mandating a strong disciplinary role for the Board provides a mediating disciplinary mechanism that can resolve problems before they are severe enough to warrant a court action.

However, as discussed in more detail below (See Issue #4) the mandated equality of treatment, and unlimited licenses of both D.O.s and M.D.s, suggest that there may be sound public policy reasons for regulating the two categories of physicians under a single board.

## ISSUE #2: Is the Board functioning effectively and efficiently now that it is located within the DCA?

**Issue #2 question for the Board and DCA:** *What specific problems has the Board had in coordinating its operations with the DCA? What specific improvements would the Board suggest? Can the Board work with DCA and other boards experiencing similar problems, to help arrive at workable solutions?*

**Background:** After nearly 80 years as an independent board, the Board was brought under the auspices of the DCA, effective July 1, 2002, pursuant to SB 26 (Figueroa). According to the Board, there have been "advantages and disadvantages to this move under the governing body of the DCA." (*Board's Sunset Review Report*, page 7)

The Board notes one clear advantage to the new relationship: access to the DCA's Consumer Affairs System, a database for licensing and enforcement data. This system, used by most of the DCA boards and commissions, allows even smaller boards like the Board to efficiently track data related to case management, licensees, complaints, etc.

However, the Board states the following among a few of the specific kinds of disadvantages it is experiencing:

> "One disadvantage is the time things take to work their way through various approval levels. For example, regulations – in the past, when submitting the Notice of Proposed Regulatory Action to the Office of Administrative Law, the Board would submit a STD 399 to the Department of General Services, Contracted Fiscal Services Department, which would forward it to the Department of Finance for approval. All of which took about 60 days. Under the DCA, the STD 399 was not sent to the DOF until the Board submitted the Rulemaking File, which caused a delay of 60 days." (*Board Response to Committee's Sunset Review Follow-up Questions*, page 3)

> "[P]rior to being under the Department of Consumer Affairs, when we would hold a meeting outside this office, i.e., board meeting, consultants committee meeting, etc., we would contact three hotels for price comparison for their meeting rooms. We pick the least expensive facility, sign an agreement with the hotel. This could all be accomplished in two to three days. After the meeting, the hotel would invoice us and the bill would be paid. Under Department of Consumer Affairs, the Contracts unit requires that we give them 90 days notice. We contact three hotels/meeting facilities, obtain bids, choose the least expensive one, then submit a contract request to the Department of Consumer Affairs contractor unit. They prepare a contract, which is forwarded to the hotel/meeting facility for their approval and signature. This involves twice the amount of paperwork and time. It does not seem cost effective to have to go through the contracts unit to obtain a simple agreement for a meeting room rental for one day which amounts to no more than $350." (Ibid.)

There is little doubt that larger bureaucracies engender a large degree of paperwork and staff time, while smaller organizations have far greater flexibility and ability to adapt to changing circumstances. Part of this has to do with assurances of accountability that are necessary in large organizations. In addition, specifically in the governmental context, the public has a right to a great deal of transparency.

However, there is equally little doubt that many times the larger systematic demands for responsibility can develop, over time, into senseless roadblocks and hurdles that prevent sound and necessary actions from occurring, or delay them beyond reasonable limits.

The Board's experience is a stark illustration of the difference between an independently functioning, smaller organization and a larger, but less nimble body. While the Board has been able to take advantage of DCA's useful database something no smaller organization could haven easily developed on its own – the Board is also caught up in some bureaucratic red tape that seems to stifle the ability of the Board to function efficiently.

## ISSUE #3: Should the Board formally adopt a Code of Ethics?

**Issue #3 question for the Board:** *Is it appropriate that, unlike M.D.s, or nearly all other licensed professionals in California, D.O.s do not have to abide by a Code of Ethics enforceable by the Board?*

**Background:** The Board does not currently have in place an enforceable Code of Ethics for its licensees. This is highly unusual among consumer protection boards.

Rather, the Board notes that its licensees are "expected" to abide by the American Osteopathic Association's (AOA) voluntary Code of Ethics. (*Board Response to Committee's Sunset Review Follow-up Questions*, page 2). This "expectation," however, is not enforceable by the Board. The Board candidly says, "Nothing in the law or regulations requires osteopathic physicians and surgeons to adhere to the AOA standards." (Ibid.)

Nor, as the board points out, does the AOA have any jurisdiction to enforce its voluntary Code if one of the Board's licensees does not abide by that Code. (Ibid.) By not itself adopting the AOA Code, or something like it – or *something* -- the Board appears to have abdicated its responsibility to adopt regulations in this exceptionally important area.

The Board has told Committee staff that the Attorney General has advised them there is no need for them to adopt a Code of Ethics. (Conversation with Linda Bergmann, Executive Director, Board on Dec. 2, 2004) This advice was, apparently oral, since the Board has no documentary evidence for it. Committee staff have not been able to confirm with the Attorney General's staff what specifically might underlie this advice, nor provide a reason that it might be sound.

The Board suggests to the Committee that the Board lacks the ability to promulgate such regulations:

> "Regulations would be impossible to obtain as there is no statute defining ethics. Ethics means conforming to a set of standards of conduct of a given profession or group, and is not defined in law." (*Board Response to Committee's Sunset Review Follow-up Questions*, page 2)

Clearly, however, the Board has full authority to promulgate regulations (the Board's existing regulations can currently be found in the California Code of Regulations, Title 16, Div. 16, section 1600 et seq.), and there is no doubt that, like virtually all boards and commissions with a mandate to protect the public interest, it has the authority to promulgate regulations concerning the ethics and professional responsibility of its licensees. (See, e.g., the regulation the Board currently has in effect, CCR, Title 16, Div. 16, sec. 1612, Evidence of Professional Responsibility) The fact that "ethics" is not, itself, defined in law, does not prevent the Board from promulgating regulations that will fulfill its ability to achieve its "paramount" duty to protect the public in carrying out its "licensing, regulatory and disciplinary functions." (B&P Code sec. 2450.1) That authority supports the ability of the Board to, itself, define what ethics are appropriate for D.O.s as a matter of protection of the public.

It appears there may be some misunderstanding involved here. One Deputy Attorney General familiar with boards and commissions suggested to Committee staff that an A.G. might have advised the Board that they should not adopt, *in its entirety*, the AOA Code of Ethics, since such national standards are frequently updated, and it would be incumbent on the Board to keep up with changes made at the national level as they are adopted. This is certainly an issue, but it is equally true of any set of standards. Even if the Board established its own Code of Conduct entirely independent of the AOA Code of Ethics, it would have to revisit it periodically to make certain it is up-to-date and appropriate in a changing environment.

The Board can easily address even the more obvious issue with the AOA Code. The Board could adopt the AOA Code in regulation by reference, in a manner that would incorporate any changes as they are adopted nationally. Or, the Board could adopt the AOA Code as it now stands, follow any national changes as they develop, and adopt – or not – any changes they choose. Or, it could adopt parts of the AOA Code the Board agreed with, and modify or adapt others.

This kind of administrative decision making is not only commonplace among boards, it is an essential characteristic of an administrative agency of any kind. Moreover, any staff time that would have to be involved in tracking changes by the national organization is more than outweighed by the current problem of having no enforceable standards in place whatsoever.

## ISSUE #4: Should the Board be merged into the Medical Board?

**Issue #4 question for the Board and DCA:** *In light of the fundamental and statutorily required equality between D.O.s and M.D.s, is there a continuing need for two separate boards to regulate those who hold unrestricted licenses as physicians and surgeons?*

**Background:** Since the initiative establishing the Board in 1922, California's public policy has been clear that D.O.s are to be treated equally with M.D.s. For example, B&P Code sec. 2453 clearly states, in subdivision (a): "It is the policy of this state that holders of M.D. degrees and D.O. degrees shall be accorded equal professional status and privileges as licensed physicians and surgeons."

Moreover, this equality is firmly enough established that it extends to a statutorily mandated rule of nondiscrimination. Subdivision (b) of section 2453 states:

> "Notwithstanding any other provision of law, no health facility subject to licensure under Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code, no health care service plan, nonprofit hospital service plan, policy of disability insurance, self-insured employer welfare benefit plan, and no agency of the state or of any city, county, city

> and county, district, or other political subdivision of the state shall discriminate with respect to employment, staff privileges, or the provision of, or contracts for, professional services against a licensed physician and surgeon on the basis of whether the physician and surgeon holds an M.D. or D.O. degree."

This equality, as well as the vastly coextensive education and training of M.D.s and D.O.s, and the exact parity of their unrestricted licenses and scopes of practice, raise a perennial question: whether there is a continual need to have two separate regulatory bodies for these virtually identical professions.

That question is particularly timely this year in light of the Governor's well-publicized desire to eliminate redundancies and inefficiencies in state government, and particularly in the structure of the state's boards and commissions. (See *California Performance Review Report*, Vol. 3, "Form Follows Function") Moreover, the Senate has created a committee specifically devoted to government accountability and modernization, one which has jurisdiction over questions of exactly this sort.

The primary difference between D.O.s and M.D.s appears to be essentially one of emphasis. According to the current Executive Director of the Board, D.O.s have a different philosophy of medicine, focused on the interrelationship of the body's systems, a focus M.D.s do not share. Aside from that, both professions apparently have identical licenses, identical scopes of practice, and must be treated by insurers, hospitals, and government entities identically. They are held to apparently virtually identical standards of practice by hospital Peer Review Organizations and liability insurers, and, in fact, both the Board and the MBC use the same prosecutors when their licensees are subject to formal accusations.

## ISSUE #5: Should the composition of the Board be revised?

**Issue #5 question for the Board:** *Is there a sound public policy reason that the Board has only two public members out of seven total Board members?*

**Background:** The Committee has consistently recommended providing a better balance of public members to professional members for health-related licensing boards. There are currently eight health-related consumer boards that have similar ratios of public to professional members: one additional professional member over that of the public membership. Two health-related boards have a public majority. The only super-professional majority boards are the Medical and Dental boards. The Board's ratio of public to professional members exceeds even the 2:1 ratio of those boards.

Since the licensee population of this Board is rather small, about 2700 active D.O.'s, the size of this board should not be increased. Instead the Legislature may wish to consider replacing one of the professional members of the Board with an additional public

member, bringing the Board's composition to 4 professional members and 3 public members (seven total members).

In addition, the Senate and Assembly should each have the authority to choose one of the public members. The unique nature of the Board's current appointment process – whereby the Governor has authority to appoint all members – is a relic of history that is now demonstrated to be inappropriate. The Governor's inability to appoint members to this board is, perhaps, understandable, given his many priorities. However, that leaves this Board, in particular, lacking members, and vulnerable to the vagaries of an administration that is overwhelmed by – to them – more important tasks. As noted above, unless the situation has changed, by the time of this hearing, the Board will have no public members at all because the Governor has not appointed anyone to fill long-expired vacancies.

The Committee recommended this change to the Board in 2000. In response, the Board concluded the following in its report to the Committee:

> "The current composition of the Board is five professional and two public members. There doesn't appear to be any need to alter this composition."

This is, of course, no explanation; simply a reiteration of the status quo.

## ISSUE #6: What is the status of repayment to the Board of the $2,700,000 loan it made to the General Fund in 2002/03?

**Issue #6 question for the Board:** *Please elaborate on how the Board intends to pursue repayment of the $2,700,000 loan it made to the General Fund in 2002/03. In light of the fact that the Department of Finance has denied the Board's request for an additional position, why doesn't the Board "need" the money now?*

**Background:** *[Note: This issue is examined in more detail in the Committee's Cross-Cutting Issue paper. Briefly, in 2002 and 2003, nineteen boards in the DCA were required to "loan" the General Fund over $200 million from their segregated, special funds. Those funds are segregated from the General Fund specifically because they are comprised of fees paid by licensees, and those fees are limited to use only for regulation of the licensees' profession, and for no other, more general purpose. The discussion here looks more specifically at this issue as it relates to this Board.]*

In 2002/03, the Board made a loan to the state's General Fund of $2,700,000.[2] In a set of follow-up questions to the Board's Sunset Review Report, the Committee requested the

[2] The Board says, in its Sunset Review Report that the loan amount was $3,000,000. (Sunset Review Report, page 10) However, documents provided to the Committee by the Senate Budget Committee show the exact amount of the loan as $2,700,000. The Executive Officer confirms that the lower figure is the correct one.

Board to elaborate on the loan it made to the General Fund in 2002/03, and specifically relate the circumstances under which the loan was made, and how the loan would be repaid. The Executive Officer stated the following in response:

> "I do not have the details but it is my understanding that the California legislature removed the funds from various Boards that had reserves (not only the Osteopathic Medical Board of California) in an attempt to balance the General Fund. I have no 'contract agreement etc.' or terms of repayment." (*Board Response to Committee Follow-up Questions*, page 4)

This is typical of the lack of information – and participation – boards had in this "loan" process. Very few true "loans" would be described as money being "removed" from a lender.

The broader questions are explored in greater detail in the Committee's report on the loan as a cross-cutting issue, but the specific circumstances of this Board's loan illuminate two critical points.

First is the fact that the Executive Officer of the Board does not know the terms of the loan or has any agreement accounting for $2,700,000 of her Board's special funds. Again, it is not characteristic of any true "loan" that the lender is both entirely passive, and, in fact, uninformed about the loan until after it has been accomplished.

Secondly, and perhaps even more important, is the question of repayment. In response to questions concerning repayment, the Committee has been able to establish only that the "borrowed" funds will be repaid to the boards when "need arises." However, because of the highly unusual circumstances of these loans, this fluctuating and highly subjective standard raises troubling questions.

For example, the Board requested budget approval for a new position, which the DOF denied. The Board's description of this process shows the Board has virtually no authority to spend its own funds without DOF approval:

> "I do not believe that the Department of Finance denied the position because of lack of our funds; it's my understanding all BCP's for new/additional positions for all departments were denied." (*Board Response to Committee Follow-up Questions*, page 4)

The Board, of course, is not a "department." Nor are its funds like those available to "departments" of state government. The Board's funds are purposely segregated from the General Fund precisely *because* its funds are prohibited from being used for General Fund purposes. If the Board has *its own funds* available to spend for *its own purposes*, the condition of the state's General Fund – and the DOF's guardian position with respect to the state's General Fund – is, or should be, irrelevant to the Board's expenditures, or expenditure requests.

*That is true, however, unless one views board special funds as being routinely available to the General Fund through "loans" like those here.* The Board's situation demonstrates that this could be the case. When the DOF denies special fund boards the ability to spend their own funds for their own purposes, the DOF may be creating a situation where boards build up surpluses that the DOF may then determine will later be "loaned" to the General Fund without consultation with the boards who are custodians of those funds.

This is confirmed by another answer from the Board. In response to a separate question concerning a Board request in 2003 for a new position, the Board answered:

> "Because of the State's fiscal crisis, BCP's submitted in fall 2003 were not reviewed and returned to the Board by the Department of Consumer Affairs at the direction of the Department of Finance. Department of Finance has the final budget authority." (*Board Response to Committee Follow-up Questions*, page 3)

This "final budget authority" is critical. If boards like the Board cannot spend their own money without DOF approval; and if DOF will not let them spend their money for needed positions; and if this causes board special fund reserves to increase; and if DOF then feels it has the power unilaterally to borrow that money; and if DOF says that the unilateral loans will only be repaid if a board needs them; and if the DOF then has the authority to prevent any such need from ever arising; then boards like the Board have no hope of ever being able to see those loaned funds repaid, except at the whim of the borrower.

That appears to be the situation the Board finds itself in. It needs a new position, which this Committee has recommended. It has requested such a position. The DOF "removed" $2,700,000 from the Board's special fund. If this does not demonstrate a "need" for repayment of at least some – if not all – of those funds, it is difficult to see what a need leading to repayment would look like.